

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
FOR STATE
HEALTH DEPT.11
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1, Page 5 may be retained for your files.12
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12965

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12971

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pear St.		e. STREET ADDRESS Hinman Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle HENRY	Last CLOUGH
4. DATE OF DEATH	Month Sept.	Day 27	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 10, 1952
9. AGE (In years lost birthday) 15 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY Jr. High School	11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jack Clough	14. MOTHER'S MAIDEN NAME Lavenia DeHaven		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Jack Clough, same as 2 abcd	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9145 DUE TO CARDIAC STANDSTILL INTERVAL BETWEEN ONSET AND DEATH SECONDS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO ELECTROCUTION FEW SECONDS lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMAR <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) GRABBED A 14,400 VOLT ELECTRIC CABLE		
20c. TIME OF INJURY Month, Day, Year Hour o.m. 4/12 p.m. 9/27 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 2 at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STREET	20f. (City or town) (County) (State) CRISFIELD, SOMERSET, MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>A. N. Barr, M.D.</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> CRISFIELD, MD. Address (Street, city, town, or county)		
EXAMINER'S NAME (Type) A. N. BARR, M.D.	22. DATE SIGNED 9/29/67		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 30, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	23d. LOCATION (City or Town) (County) (State) Crisfield, Md.
24. FUNERAL DIRECTOR Bradshaw & Sons — Crisfield, Md.	25a. REC'D. BY REGISTRAR DATE OCT 4 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12972

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

12966

1. PLACE OF DEATH a. COUNTY Somerset Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E. Prince Williams Street		d. STREET ADDRESS 412 Poplar Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALICE MAE COULBOURNE		First Middle Last	4. DATE OF DEATH September 2 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 18, 1902
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years lost birthday) 65 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wicomico County, Maryland	
13. FATHER'S NAME Joshua James Coulbourne		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME Mary Ellen Timmons	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Alton L. Adkins (Son) 602 E. College Ave., Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH minutes	
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. C. Sutter, Dames Quarter, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Somerset	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 5, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE SEP 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12967

12973

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Last) First (Type or print) Olan		Middle H. Cullen	4. DATE OF DEATH Month Sept. 27 Year 1967
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Super Market	8. DATE OF BIRTH Sept. 29, 1910
10c. MOTHER'S NAME Wade Cullen		9. AGE (In years last birthday) 56 yrs.	11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Ola Garrison	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-6115	17. INFORMANT Miss Mary Cullen — Arlington, Va. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO <i>Myocardial infarction</i> INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9/27/67 19____, and that death occurred at 5:05 P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>C. G. Rawley.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Oct 4 1967
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, Md.		22d. ADDRESS Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 30, 1967	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery
24. FUNERAL DIRECTOR Bradshaw & Sons —		ADDRESS Crisfield, Md.	25a. DEATH REGISTRAR OCT 4 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

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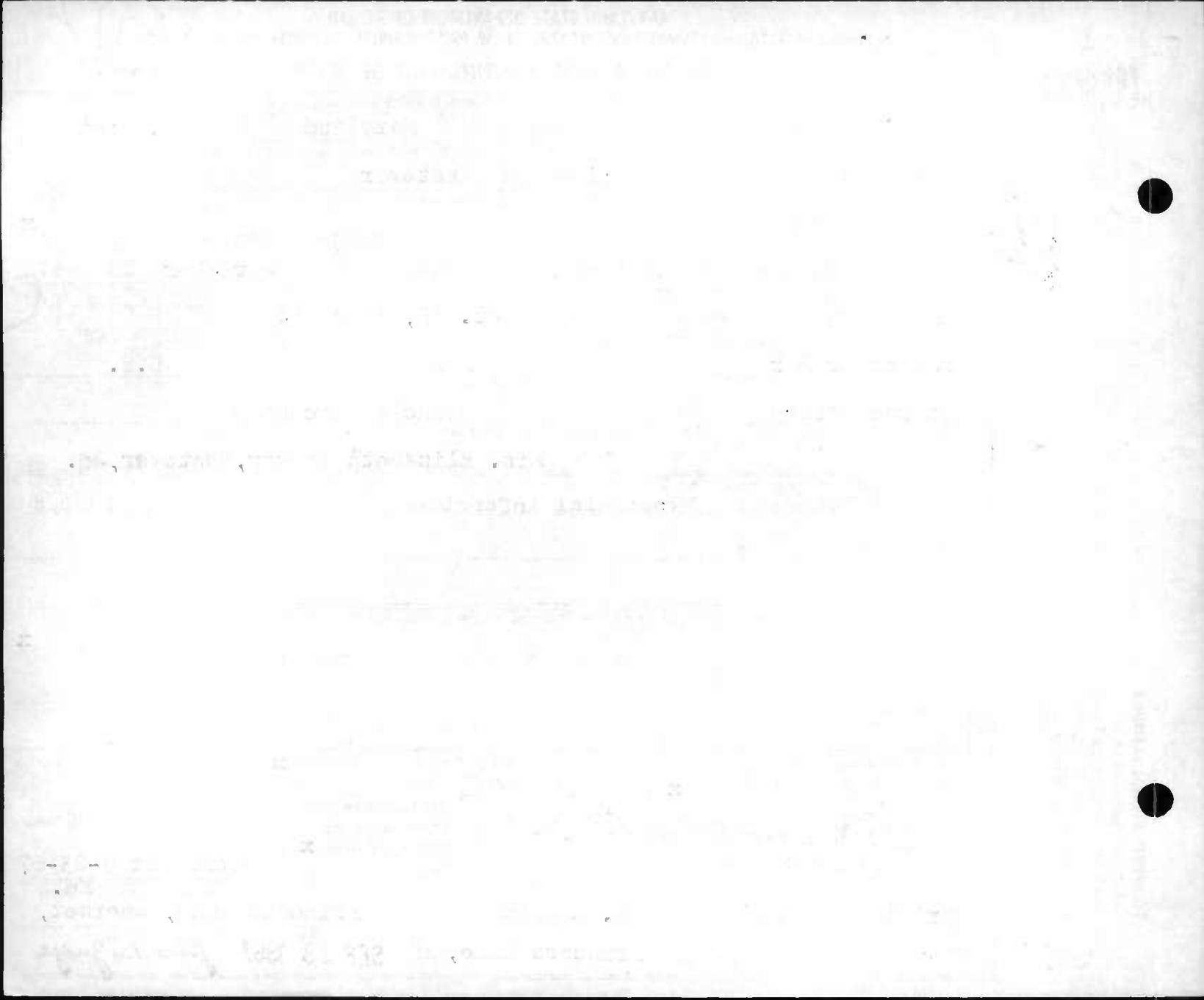
MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12968

12974

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		c. LENGTH OF STAY IN lb life		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westover		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19-1		
3. NAME OF DECEASED (Type or print) Thomas Washington Dorsey		First Thomas	Middle Washington	
4. DATE OF DEATH September 22 1967	Last Dorsey	Month September	Day 22	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1913	
9. AGE (In years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Broker	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Dorsey	14. MOTHER'S MAIDEN NAME Blanche Beauchamp	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Elizabeth Dorsey, Westover, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH minutes		
DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <i>Everett Sutter</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Everett Sutter MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Somerset 9-23-67
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/67	23c. NAME OF CEMETERY OR CREMATORIAL St. Andrews	23d. LOCATION (City or Town) (County) (State) Princess Anne, Somerset, Md.
24. FUNERAL DIRECTOR James Sutler		ADDRESS Princess Anne, Md.	25a. REC'D BY REGISTRAR DATE SEP 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12975

12969

CERTIFICATE OF DEATH

1 **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

<p>1. PLACE OF DEATH a. COUNTY Somerset MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 40 yrs 1/Hour</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield</p> <p>d. STREET ADDRESS Chesapeake Avenue</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>177</p> <p>3. NAME OF DECEASED (Type or print) Henry B. ENNIS</p> <p>First Middle Last</p>		<p>4. DATE OF DEATH Sept. 1 1967</p> <p>Month Doy Year</p>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1905	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carmen Cutter		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (County & State, or foreign country) Somerset, Maryland	
13. FATHER'S NAME Sidney Ennis		14. MOTHER'S MAIDEN NAME Rose Matthews		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 216-12-1297		17. INFORMANT Mrs. Mary Ennis, Same as 2. abcd above	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 2 hours 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Insufficiency 13 years lost. DUE TO (c) Generalized Arteriosclerosis Unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/12 1954 to 9/1 1967 , that (I) (we) last saw the deceased alive on Sept. 1, 1967 and that death occurred at 5 A , fram causes and an the date stated above.					
22a. SIGNATURE <i>A. N. Barr, M.D.</i>		22b. DATE SIGNED 9/4/67			
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		22d. ADDRESS Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 4, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Rehobeth Baptist Cemetery	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Maryland		ADDRESS		23d. LOCATION (City or Town) (County) (State) Rehobeth, Maryland	
25a. REC'D BY REGISTRAR SEP 6 1967		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>			
DATE					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12976

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
Somerset		a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Crisfield		Crisfield			
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS			
35 years		15 Wynnfall Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Crisfield Amoco Service Station South Seventh St.					
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH			
First DONALD		Middle CARLISLE	Month Sept. 15		
Last EVANS		Year 1967			
5. SEX Male		6. COLOR OR RACE White			
7. MARRIED WIDOWED		8. DATE OF BIRTH May 24, 1922			
9. AGE (In years lost birthday) 45 yrs.		10. KIND OF BUSINESS OR INDUSTRY Service Station			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		11. BIRTHPLACE (State or foreign country) Rhodes Point, Md.			
13. FATHER'S NAME Roosevelt C. Evans		14. MOTHER'S MAIDEN NAME Mary Sneade			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes WW II		16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Lillian B. Evans, same as 2 abcd above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound, chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Doy, Year approx. 7 pm 9/15/67		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury sustained while cleaning gun.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) Serv. Sta. 7th St. Crisfield Som. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 9/18/67			
ACTUAL SIGNATURE C. G. Rawley, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Crisfield, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 17, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	
24. FUNERAL DIRECTOR Bradshaw & Sons		ADDRESS Crisfield, Md.		25a. REC'D BY REGISTRAR DATE SEP 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12971

CERTIFICATE OF DEATH

12977

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE		
Somerset MARYLAND		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 48 yrs/2/06/67		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		d. STREET ADDRESS 13 Pear Street		
3. NAME OF DECEASED (Type or print)		First Milton	Middle I.	
4. DATE OF DEATH 9-16-67		Lost Evans	Month Year Doy Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec 5, 1897		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months Doy Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman & Dealer		11. BIRTHPLACE (County & State, or foreign country) Somerset, Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Evans		14. MOTHER'S MAIDEN NAME Ann Bradshaw		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 204-09-7644	17. INFORMANT M. James Evans, New Carrollton, Md. Address 8331 Verona Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/13, 1967 to 9/16, 1967, that (I) (we) last saw the deceased alive on 9/16/67 19, and that death occurred at 2:30 M, from causes and on the date stated above.		22b. DATE SIGNED 9/18/67		
22a. SIGNATURE An. Barr, M.D.		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Dr. A. N. Barr		22d. ADDRESS Crisfield, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 19, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery	23d. LOCATION (City or Town) Crisfield, Md. (County) (State)
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		ADDRESS		25a. REC'D. BY REGISTRAR SEP 25 1967
				25b. REGISTRAR'S SIGNATURE James Judge

NAME: WILLIAM J. BROWN

ADDRESS:

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12972 12978

1. PLACE OF DEATH a. COUNTY Somerset			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			b. COUNTY Somerset		
c. LENGTH OF STAY IN 1b life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			19-1		
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			1967		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
William	E.	Fooks	9	12	1967
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. FUNDER 1 YEAR Months Days Hours Min.
m	c	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-12-1882	85 yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11b. KIND OF BUSINESS OR INDUSTRY Retired		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? UXSA		
13. FATHER'S NAME William Fooks			14. MOTHER'S MAIDEN NAME Matilda Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 17. INFORMANT Rose Anna Derman, Princess Anne, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure			Address INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease			years		
DUE TO (b) Arteriosclerotic Heart disease					
DUE TO (c) Arteriosclerotic Heart disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Everett Sutter M.D.</i>					
EXAMINER'S NAME (Type) Everett Sutter					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) Somerset 9-14-67					
22. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 23d. LOCATION (City, town or county) (State)					
Burial 9-17-67 John Wesley			Princess Anne Md		
24. FUNERAL DIRECTOR					
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 18 1967 <i>Charles Judge</i>					
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

12973

12979

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rehobeth		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital			d. STREET ADDRESS --			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Ada	Middle E	Lost Howard	4. DATE OF DEATH 9 - 16- 67	Month Year 1967	Doy 16
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 3, 1887	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Doys 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Sussex County, Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Windsor			14. MOTHER'S MAIDEN NAME Laura Ann Hastings			Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) No			16. SOCIAL SECURITY NO. 214-54-7113			17. INFORMANT Ernest F. Howard, Rehobeth, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Respiratory Failure - Few minutes DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cerebral Vascular Accident DUE TO lost. (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar 13, 1961 to Sept 16, 1967 , that (I) (we) last saw the deceased alive on 9/16/67 1967, and that death occurred at 9:30 , from causes and on the date stated above.						22b. DATE SIGNED 9/18/67
22a. SIGNATURE G. N. Barr, M.D.						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Sr. A. N. Barr, M.D.						22d. ADDRESS Crisfield, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-1967		23c. NAME OF CEMETERY OR CREMATORIUM Bethany Methodist		23d. LOCATION (City or Town) (County) (State) Pocomoke City - W. Md.
24. FUNERAL DIRECTOR Robert H. Watson			ADDRESS Pocomoke City, Md.			25a. REC'D BY REGISTRAR DATE SEP 22 1967
						25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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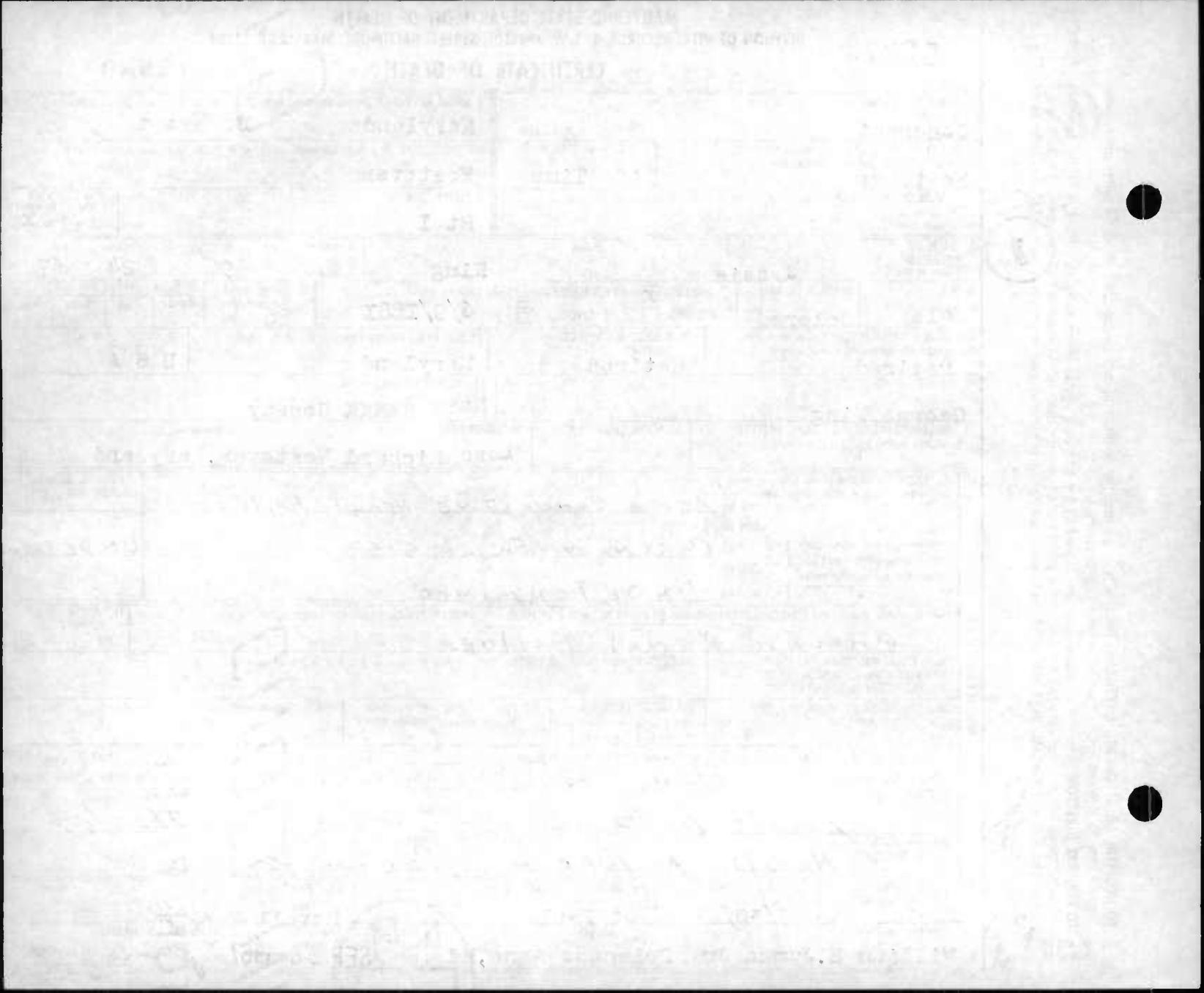
12974

CERTIFICATE OF DEATH

12980

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland COUNTY Somerset						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		c. LENGTH OF STAY IN lb Life Time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		d. STREET ADDRESS Rt I				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Jessie		First	Middle	Last	4. DATE OF DEATH King	Month 9	Day 24	Year 1967		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1881		9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George King				14. MOTHER'S MAIDEN NAME Mary XXXX Conway						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.						
17. INFORMANT Lena Richard Westover, Maryland				Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) CORONARY SCLEROSIS DUE TO last. (c) UNDETERMINED.									INTERVAL BETWEEN ONSET AND DEATH UNDETERM	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC RENAL FAILURE									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 9/24 1967 and that death occurred at 6:00 PM , from causes and on the date stated above.										
22a. SIGNATURE <i>Neville A. Baron</i>				22b. DATE SIGNED 9/25/67						
22c. PHYSICIAN'S NAME (Type) Neville A. Baron				22d. ADDRESS Pocomoke, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/30/67		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul		23d. LOCATION (City or Town) (County) (State) Westover P.O.				
24. FUNERAL DIRECTOR William H. James Jr				25a. REC'D BY REGISTRAR Revell Neg. No.						
ADDRESS Princess Anne, Md.				25b. REGISTRAR'S SIGNATURE Charles Judge						
DATE SEP 28 1967										



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12975

12981

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Somerset MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb 1/3 50 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First (Lewis) Louis		Middle P	4. DATE OF DEATH Month Sept. 15 Doy 15 Year 1967
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman/Boat Capt.		8. DATE OF BIRTH May 31, 1889	
10b. KIND OF BUSINESS OR INDUSTRY Seafood		9. AGE (In years last birthday) 78 yrs.	
13. FATHER'S NAME Travis Parks		11. BIRTHPLACE (County & State, or foreign country) Tangier, Va.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-14-4359	
17. INFORMANT Ralph W. Parks, Same as 2. abcd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes Mellitus</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause _____ DUE TO _____ lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 9/15/67 19_____, and that death occurred 2:05 M, from causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>C. G. Rawley</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		22d. ADDRESS Crisfield, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 18 1967	23c. NAME OF CEMETERY OR CREMATORIAL SUNNYRIDGE CEMETERY
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		23d. LOCATION (City or Town) (County) (State) Crisfield, Md.	
ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 20 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12973		CERTIFICATE OF DEATH						12983		
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield Life 6/19/67				c. LENGTH OF STAY IN lb 1b						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital				d. STREET ADDRESS 313 Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Clarence		First John	Middle Clarence	1b. 1b.	Lost Somers	4. DATE OF DEATH Sept. 19 1967	Month Sept.	Day 19	Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sr. Dec 21, 1896		9. AGE (In years last birthday) yrs. 70	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner & Sales		10b. KIND OF BUSINESS OR INDUSTRY Drug & Furniture		11. BIRTHPLACE (County & State, or foreign country) Somerset, Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME J. Fletcher Somers				14. MOTHER'S MAIDEN NAME Manie Holland				Address Mrs. Flora T. Somers, Same as 2. abcd		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. WW 1 212-14-4348		17. INFORMANT Mrs. Flora T. Somers, Same as 2. abcd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 6 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9/19/67 19____, and that death occurred at 1:55 A.M. from causes and on the date stated above.										
22a. SIGNATURE C. G. Rawley, M.D.		M.D. ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/20/67						
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		22d. ADDRESS Crisfield, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 22, 1967		23c. NAME OF CEMETERY OR CREMATORIUM St. Peter's Cemetery		23d. LOCATION (City or Town) (County) (State) Crisfield, Somerset, Md.				
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.				ADDRESS			25a. REC'D. BY REGISTRAR SEP 25 1967		25b. REGISTRAR'S SIGNATURE James Judge	
VR A15 (4) 25M 1/67										

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MARYLAND STATE DEPARTMENT OF HEALTH

1297 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS 40 Chesapeake Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 40 Chesapeake Ave.				d. STREET ADDRESS 40 Chesapeake Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First THOMAS	Middle CLINTON	Last STERLING, SR.	4. DATE OF DEATH Sept. 27	Month Sept.	Day 27	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1900	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 67	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John W. Sterling		14. MOTHER'S MAIDEN NAME Mary Daugherty		15. INFORMANT Mrs. Hattie Sterling, same as 2 abed				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Acute Heart Failure		INTERVAL BETWEEN ONSET AND DEATH inhalation						
(b) DUE TO Myocardial Heart Disease		4 mo -						
(c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield	(County) Md.	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from Sept. 27, 1967 to Sept. 27, 1967 , that (I) (we) last saw the deceased alive on Sept. 26, 1967 , and that death occurred at 2 PM , from causes and on the date stated above.								
22a. SIGNATURE Sarah M. Peyton		M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED 10/6/67		
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M.D.		22d. ADDRESS Main St. -- Crisfield, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Crisfield Cemetery	23d. LOCATION (City or Town) Crisfield, Md.				
24. FUNERAL DIRECTOR Bradshaw & Sons -- Crisfield, Md.		ADDRESS Bradshaw & Sons -- Crisfield, Md.		25a. REC'D BY REGISTRAR OCT 9	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE 1967		

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